METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

B. **ADJUSTMENTS TO THE BASE YEAR COST AND CALCULATION OF STANDARD PNF RATE**

1. **INFLATION FACTORS**

OHCA staff will adjust the base year average per diem non-capital cost to account for projected inflation between the mid-point of the base year and the midpoint of the rate period. In connection with the ratesetting process for the periods of January 11, 1996 to December 31, 1996, and January 1, 1997 to June 30, 1997, the Authority utilized the Data Resources, Inc. ("DRI") nursing facility market basket index, as published for the third calendar quarter of 1995. The DRI inflation factors for CY 1995 and to the midpoint of calendar 1996, 3.1% and 1.65% (3.3 x .50) respectively, were applied to the base year average non-capital costs. The projected cost to the CY 1996 rate period is $167.67 per day.

2. **FURTHER ADJUSTMENTS FOR UNEXPECTED COSTS**

The Authority also considers possible effects on rate year costs compared to base year costs that might not be fully accounted for by the DRI index described above. Inasmuch as the index is an estimate of actual and forecasted national rates of change in the price of nursing home goods and services, DRI is not specific to any state. Thus, during a given period, it might not sufficiently account for the economic effects of changes in federal laws or regulations which have a disparate impact on Oklahoma, or of changes in state laws, rules or circumstances that only affect Oklahoma.

The following circumstances may cause an adjustment to rate year costs: Additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation authorities, or applicable law (e.g., minimum staffing requirements, social security taxation of 501(c)(3) corporations, minimum wage change, etc.) and implementation of federal or state court orders and settlement agreements.

OHCA will evaluate available financial or statistical information, including data submitted on cost reports and special surveys to calculate any base rate adjustments. We will continue to set rates in this manner until enough Medicaid cost report data becomes available.

For calendar year 1996 and the period January 1, 1997 to June 30, 1997, OHCA will allow a 8.9% ($14.92) adjustment to cover unanticipated increased cost. The adjustment is the 4 year average of the differences between the DRI marketbasket increases (HCFA nursing home without capital) and the actual rates of increases as per the audited cost reports.

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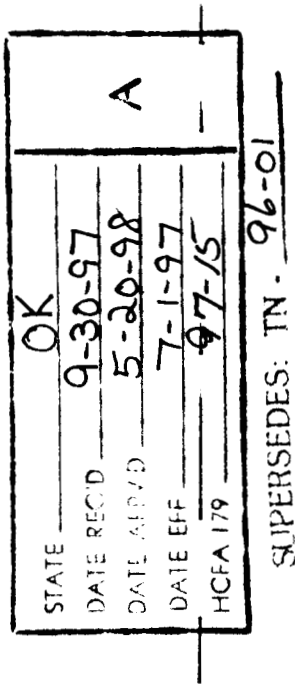
3. **CAPITAL**

An imputed allowance for capital expense is added to the base year non-capital cost in lieu of actual depreciation, interest, and lease related to facilities and equipment. A fair rental value of $4.23 per bed was derived initially in 1985 by the Department of Human Services from an analysis of construction costs identified from Certificate of Need applications and consideration of appropriate costs of debt and non-debt financing. The $4.23 is adjusted to the midpoint of the rate year by using the Marshall Swift replacement cost multipliers for facilities with Class C construction (District Comparative Cost Multipliers, Central Region) published in the July 1995 index, and multiplied by the available patient days of the pediatric nursing facilities to arrive at the projected replacement costs. The replacement costs are adjusted by an imputed occupancy percentage of .88, and divided by the FY 94 actual patient days of nursing facilities serving pediatric patients to arrive at an allowance of $6.07 for CY 96 and for the period of January 1, 1997 to June 30, 1997.

4. **ENHANCEMENTS**

The Authority may further adjust the base year average non-capital costs to include estimates of the cost of enhancements in services that are not otherwise required by law but which the Authority wishes to recommend as the basis for inclusion in the PNF rates. No such enhancements were required for calendar year 1996 or the period of January 1, 1997 to June 30, 1997.



5. **COSTS OF COMPLIANCE WITH OMNIBUS BUDGET RECONCILIATION ACT (OBRA) OF 1987**

All of the costs of compliance appear in provider cost reports used to develop rates. Therefore, no further adjustment or add-on is required.

6. **SUMMARY CALCULATION OF STANDARD PNF RATE**

The standard rate for all Medicaid-participating PNFs for calendar year 1996 is and the period of January 1, 1997 to June 30, 1997 is:

FY '95 average per diem non-capital costs including audit adjustment	$159.99
inflation adjustment	$ 7.68
(Fiscal 1996; 3.1%, midpoint of calendar 1996; 1.65%)	
further adjustments or carryovers	$ 14.92
capital allowance for CY '96 and January 1, 1997 to June 30, 1997	$ 6.07
enhancements	$ .00
Total	188.66

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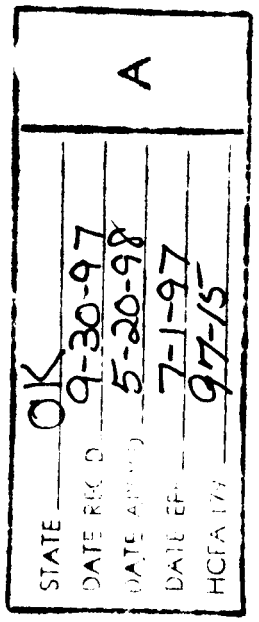
C. **RATE CALCULATIONS FOR FUTURE PERIODS**

1. The base rate, as determined in (A) and (B), will be used to determine the prospective rate for future periods beginning on and after July 1, 1997. The components of the base rate as determined in (A) and (B) are:

Operating Component	$182.59
Capital Component	$ 6.07
Total Base Rate	$188.66

(2) The rate year period will be July 1 through June 30, each year. Rates for periods beginning on or after July 1, 1997, will be determined as follows:

(a) The capital component of the rate for a new period will be the capital component of the rate for the immediately preceding rate period adjusted from the midpoint of that period to the midpoint of the new rate period by the latest available published Marshall-Swift replacement cost multipliers for facilities with Class C construction (District Comparative Cost Multipliers, Central Region).



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(b) The operating component of the prospective rate for a new period will be the operating component of the rate for the immediately preceding rate period adjusted from the midpoint of that period to the midpoint of the new rate period by the latest available published DRI (Data Resources Incorporated) Nursing Facility Market Basket Index, plus adjustments as follows:

(1) **Patient Mix Adjustment**

An additional adjustment (up or down) will be made to the operating component for the change in mix of acuity of the type of patient days as reported on the cost reports and supplemental schedules for the two most recently received cost reports prior to the rate year. The percent change (up or down) from one year to the next will be calculated as the change in the "overall" cost per day using base year costs, and the days/mix of the two most recently received reports. That is, the change in the "overall" base year cost per day given the current case mix versus the preceding period's case mix will be used to adjust the rate for the rate period.

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The case mix measures of acuity will be the annual number of days patients are classified as follows:

Categories of Care - Acuity Levels

Upon admission, each child is assigned an **Admission Category** of either Subacute Pulmonary, Rehabilitation, or Long-Term care/Habilitation depending on which admission criteria are met. The child is also assigned a **Category of Care**, which distinguishes their acuity level.

- Ventilator and/or Hyperalimentation
- Pulmonary Complex/Medical Complex
- Pulmonary Routine
- Medical Routine

These four **categories of care** are based on acuity levels of each child and they also correlate with the cost of care. A patient may be admitted into one category, and as progression or regression is seen, he may be changed to a different category.

The Business Office staff maintains the records and enters the data into a computer. These numbers are verifiable and auditable through the computer report which is generated "Patient Daily Census for (MONTH YEAR)." the report includes patient name, category of care, admit date, discharge date, discharge code, therapeutic days absent this month, therapeutic days YTD, number of days, number of days paid, and payor type. The Utilization Review nurse assigns the category of care upon admission, reviews and updates the category of care every 90 days or as significant changes take place, and upon discharge.

Criteria for Each Category of Care

Ventilator/Hyperalimentation

Any child who is ventilator dependent, requires a ventilator at night, or has a ventilator on stand-by will be assigned to this category of care.

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Any child who has continuous or intermittent total parenteral nutrition (TPN) or receives nutralipids will be assigned to this category of care.

Complex Pulmonary/Complex Medical

Children with any of the following diagnoses will be assigned to this category:

- Bronchopulmonary Dysplasia
- Hyperreactive or Reactive Airway Disease
- Neuromuscular Disorders affecting the pulmonary status of the child or airway management
- Respiratory Distress Syndrome
- S/P Respiratory Arrest
- S/P Near SIDS affecting the pulmonary status of the child or airway management
- S/P Near Drowning affecting the pulmonary status of the child or airway management
- Anoxic Encephalopathy affecting the pulmonary status of the child or airway management
- Uncontrolled Seizure Disorder

And/or any child with any of these requirements:

- Frequent suctioning and chest physiotherapy
- Tracheostomy care and management
- Customized fitted tracheostomy
- Continuous or intermittent oxygen administration
- Speaking valve for tracheostomy
- Enteral feedings
- Recovery from surgery or acute illness
- Isolation precautions
- Cast Care
- Nutritional Support for Weight <5th%
- Nebulizer and metered dose inhaler therapy
- Cardiac and apnea monitoring
- Continuous or intermittent pulse oximetry
- Feeding therapy
- Intravenous therapy or injections at least daily
- Sterile dressing changes
- Management of seizure disorders
- Urinary catheterization at least daily
- Ostomy care
- Complex airway management

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Pulmonary Routine

Any child who has one of the above pulmonary diagnoses or care requirements, but who is more stable, will be assigned to the category **Pulmonary**. This is a lower acuity level. Because the child is more stable, the above procedures may be required less frequently, or they may be intermittent rather than continuous.

Medical Routine

To be placed in this category, a child will not have a primary diagnosis reflecting a pulmonary condition. The above care requirements may be the same as **Complex Medical**, but they are not as frequent and may not be daily. The child may or may not receive enteral nutrition.

(2) **Adjustment to the Operating Component for Changes in Law or Regulations**

The Authority will also consider possible effects on rate year costs compared to base year costs that might not be fully accounted for by the DRI index or case mix adjustment as described above. Inasmuch as the index is an estimate of actual and forecasted national rates of change in the price of nursing home goods and services, DRI is not specific to any state. This, during a given period, it might not sufficiently account for the economic effects of changes in federal laws or regulations which have a disparate impact on Oklahoma, or of changes in state laws, rules or circumstances that only affect Oklahoma.

The following circumstances may cause an adjustment to rate year costs: Additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation authorities, or applicable law (e.g., minimum staffing requirements, social security taxation of 501(c)(3) corporations, minimum wage change, etc.) and implementation of federal or state court orders and settlement agreements.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
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A statewide prospective rate of payment shall be computed at least annually for nursing facilities serving AIDS patients. The rates will be established by the Oklahoma Health Care Authority upon receipt of recommendations from the Rates and Standards Committee composed of knowledgeable staff from OHCA. The OHCA Board shall take into consideration information obtained from public meetings, cost reports and negotiations with recognized representatives of the nursing home industry. The payment rates will be set at the level which OHCA finds adequate to reimburse the costs of a facility which is economically and efficiently operated. Recognized economic factors will be included in the determination of the prospective rates. Such consideration shall include noted trends in national and state Consumer Price Indices and factors such as prevailing salary levels of health care professionals and changes in the law governing minimum wage levels. The rates will take into account the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under Title XIX) of complying with subsections (b) (other than paragraph (3)(F) thereof), (c), and (d) of Section 1919 and provide (in the case of a nursing facility with a waiver under Section 1919(b)(4)(C)(ii)) for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care.

Uniform cost reports will be required of such nursing facilities and the State will provide for periodic audits of such reports. The method of reporting will be the same as that for regular NFs as described in Attachment 4.19-D, Page 1 through 1.2.

This rate will provide reimbursement to recognize the unique costs of care and to promote access to services by patients who require them. Although any given patient, whether they have AIDS or something else, may require an especially intense level of care, the effect of this cost on the nursing home as a whole will depend on the overall case mix of patients in the home, or, on what the demands on the home's resources are on average.

1.

DEVELOPMENT OF RATE

a. Non-Capital Cost – In developing the rate, OHCA will use the most recently available cost reports filed by facilities serving only AIDS patients. From these reports, OHCA staff will determine a statewide average primary operating cost. The primary operating cost is defined as the total allowable cost less audit adjustments and net of the cost of capital and administrative services as described in Attachment 4.19-D, Pages 1.2 through 1.4.

Oklahoma
DATE RECD 9-30-97
DATE APPD 8-9-99
DATE EFF 7-1-97
HCFA-179 97-16

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b. **Administrative Services** – The imputed allowance for all NFs, as described in Section 3.B. of Attachment 4.19-D, Page 1.3, will be added to the primary operating cost in (a) above to arrive at the total operating cost portion of the rate.

c. **Inflation Factors** – The operating cost portion of the rate will be adjusted by the inflation factors used for the regular nursing facilities as described in Sections A. and B. of Attachment 4.19-D, Page 1.3.

d. **Capital** – An imputed allowance for capital expense will be added to the base year non-capital cost. This allowance is the same as that for regular NFs as described in Section C. of Attachment 4.19-D, Page 1.3.

e. **Enhancements** – The Authority may further adjust the base year average non-capital costs to include estimates of the cost of enhancements in services that are not otherwise required by law but which the Authority wishes to recommend as the basis for inclusion in the NF rates. The enhancement is the same as that for regular NFs as described in Section 4 of Attachment 4.19-D, Page 1.4.

f. The total rate will be the sum of the portions determined in a. to e. above.

STATE Oklahoma
DATE REC'D 9-30-97
DATE APPV'D 8-9-99
DATE EFF 7-1-97
HCFA 179 97-16

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR NURSING FACILITIES

A statewide enhanced reimbursement rate shall be computed at least annually for nursing facilities (NFs) serving ventilator-dependent patients.

Definitions - Reimbursement is limited to the average rate paid to NFs serving adults plus an enhancement for ventilator patients. The enhanced payment is an amount reflecting the additional costs of meeting the specialized care needs of ventilator-dependent patients. To qualify for the enhanced payment, a facility must (1) not have a waiver under Section 1919(b)(4)(C)(ii) of the Social Security Act, and (2) submit a treatment plan and most recent doctor's orders and/or hospital discharge summary to the Oklahoma Health Care Authority for prior authorization.

Rate Determination - The add-on rate is determined prospectively as follows:

1. The estimated cost of direct care personnel is calculated using ventilator care-related criteria developed by the State of Minnesota. The criteria identifies the tasks, caregiver time estimate (in minutes per day) and caregivers (RN, LPN, etc.) required to complete each element of care on a daily basis. (For blood gas tasks, a respiratory therapist was substituted for the RN).

2. Each caregiver time estimate, within each task category, is added together to arrive at a total caregiver time estimate within each task category. The total caregiver time estimate is converted to hours per day. It is then multiplied by a projected hourly wage rate by class of caregiver to arrive at a cost per day for each caregiver within each task category. Each cost per day for each caregiver is added together to arrive at a total caregiver cost within each task category. Each total caregiver cost is added together to arrive at a total caregiver cost to complete all identified tasks. The projected hourly wage rates were derived from the most recently available NF cost reports.

3. A factor for fringe benefits is calculated by dividing total employee benefits by total salaries and wages. The total caregiver cost to complete all identified tasks is multiplied by the factor for fringe benefits to arrive at a fringe benefit cost. The fringe benefit cost is added back into the total caregiver cost to complete all identified tasks to arrive at an adjusted total caregiver cost. Total employee benefits and total salaries and wages was derived from the most recently available NF cost reports.

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4. Based on provider input, and other survey information, the estimated average hours of specialized care required by ventilator-dependent patients was 9 hours per day. Each caregiver time estimate within each task category was added together to arrive at a total time estimate to complete all identified tasks, which was 13.69 hours. The adjusted total caregiver cost is multiplied by the ratio of 9 hours divided by 13.69 hours to arrive at a specialized caregiver cost.

5. The total patient care cost from the most recently available NF cost reports was calculated. The total patient care costs include nursing personnel including nursing employee benefits, medical director including employee benefits, social and ancillary service personnel including employee benefits, contract nursing, other contract personnel, medical equipment, dietary, drugs and medical supplies.

6. The difference between 24 hours and the estimated average hours of specialized care required by ventilator-dependent patients (9 hours) is divided by 24 hours. It is then multiplied by the total patient care cost which is then added to the specialized caregiver cost to arrive at the total 24 hour cost of patient care.

7. Five percent of the total patient care cost will be allowed for the additional cost of medical supplies not reimbursed by Medicare. A $4.00 per day adjustment will be allowed for nutritional therapy. Both additional costs are added back into the total 24 hour cost of patient care.

8. The difference between the total 24 hour cost of patient care (step 6) and the total patient care cost (step 5) is the add-on for ventilator patients.

9. The add-on for ventilator patients was inflated to the midpoint of the rate year using the fourth quarter publication of the Data Resources Inc., (DRI) Nursing Facility Marketbasket Index's forecast.

Cost Report Requirements - Uniform cost reports will be required of such nursing facilities and the State will provide for periodic audits of such reports. Facilities will be required to submit a separate cost report for ventilator care.